

SL 15362

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45924
STATE FILE NUMBER

FILED DEC 30 1957

318

Registration District No.

1003

Primary Registration District No.

Registrar's No. 42183

V. S. 300
ev. 1-57

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| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N Grand St. Louis, Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN EAST ST. LOUIS 812 E | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 V. A. HOSPITAL | | Length of stay in lb 8 Days | d. STREET ADDRESS 32 1758 N 58th | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE HOLCOMB | | | 4. DATE OF DEATH 12/18/57 Month Day Year | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/20/93 | | 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (City and state or country) Haywood County, Tenn. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13a. FATHER'S NAME NEVIL HOLCOMB | | 13b. MOTHER'S MAIDEN NAME LEATHY FALKNER | | 14. NAME OF HUSBAND OR WIFE XXXXX NONE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO. 333-03-0642 | | 17. INFORMANT Address VA HOSPITAL RECORDS ST. LOUIS, MISSOURI | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) - 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PULMONARY INFARCTION | | | | | INTERVAL BETWEEN ONSET AND DEATH OLD & RECENT |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> NONE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) - | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 20f. CITY, TOWN, OR LOCATION - | | COUNTY STATE | |
| 21. I attended the deceased from 12/10/57 to 12/18/57 and last saw him alive on 12/18/57 Death occurred at 8:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Name or title) J. T. Kaminski | | 22b. ADDRESS M.D. VA HOSPITAL ST. LOUIS, MISSOURI | | 22c. DATE SIGNED 12/18/57 | |
| 23a. BURIAL CREMATION, REMOVAL 12/18/57 | | 23c. NAME OF CEMETERY OR CREMATORY J. T. KAMINSKIAS M.D. | | 23d. LOCATION (City, town, or county) (State) East St. Louis, Illinois | |
| 24. FUNERAL DIRECTOR John J. Kaminski | | 25. DATE RECD. BY LOCAL REG. DEC 18 57 | | 26. REGISTRAR'S SIGNATURE Karl Smith MD m 813. | |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Securing the medical certification in the specific manner required by 193.140 MONS 1949.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Joseph J. Gault*

Licensed Embalmer No. *75411*

P. O. Address *E. H. Lewis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.